DEPARTMENT OF ECONOMIC SECURITY

Your Partner For A Stronger Arizona

Claims Submission Guide

DIVISION OF DEVELOPMENTAL DISABILITIES

Updated- May 23, 2016

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Purpose and Objective

The purpose and objective of this document is to provide DDD Providers an overall view and analysis of the billing submission process and steps in addition to providing them with contact information for any questions or concerns.

Overview of the Claims Submission Process

Claims submitted to the Division of Developmental Disabilities (DDD) are edited by DES/DDD's claims processing system. The process begins with a check of the quality and completeness of data entered on the claims, followed by system edits ensuring data fields are valid and logical.

Claims for services must be submitted on the correct form for the type of service billed. Claims that are illegible or not submitted on the correct form will be returned to the provider unprocessed. The provider is responsible for resubmitting claims on the correct claim type within the appropriate time frame.

Billing Assistance, Training and Support

Provider training and assistance is available. Training sessions can be arranged through the Division's Business Operations, Provider Relations Unit, available at DDDProviderRelations@azdes.gov. In addition, support is available to the providers for billing and claims submission questions via Provider Relations Unit at 1-866-229-5553.

Submitting Claims

Providers are encouraged to use the Division's electronic billing claims process, this method facilitates expedited processing of claims and review of denials. There are three ways to file a claim with DDD.

1. Electronic Billing Submission – LTC/HCBS Services
2. CMS 1500 (837 Professional Billing Submission) – Medical and Professional Services
3. Manual (Paper) Claim Form Submission

Requirements and Process for Electronic Billing Submission

Services (LTC/HCBS Services) delivered to a specified consumer can be included on the electronic billing form. One billing may be submitted to the Division per month.

Completing Electronic Billing Documents

Two documents are required for the electronic billing process:

a) Cover sheet:
https://des.az.gov/sites/default/files/DDD-1590AFORFF.doc

b) Uniform Billing Template (UBT):
https://des.az.gov/sites/default/files/uniformbillingexceltemplate.xls

Refer to, "How to Complete the DES/DDD Uniform Billing Template (UBT)"section of this document regarding the proper methodology of how to properly fill out the Uniform Billing Template (UBT). In

addition to listing claims submitted for the first time, the UBT can include re-submission of previously denied claims. The UBT can include claims for services provided across different DES/DDD districts and claims for services provided in multiple months within the same fiscal year.

The Division's Electronic Billing process is in accordance with the Electronic Import Specification and HIPAA compliant claims processing and payment system capable of processing, cost avoiding and paying claims in accordance with ARS 36-2903, 2904. The specifications are posted on the DDD website under billing. “Professional Billing System Electronic Import Specification" located at:

https://des.az.gov/sites/default/files/uniformbillingcolumndefsofficial.pdf

CAUTION: Making changes to the UBT outside of the blank cells (i.e. changing the header name, modifying column names, deleting columns) will result in an unsuccessful claim submission.

CMS 1500 and the 837 Professional Billing Submission Requirements and Process

The 837 Professional is the standard format used by health care professionals to transmit health care claims electronically, while the CMS 1500 is the standard paper claim format. The 837 Professional is the electronic correspondent to the paper CMS 1500 claim form; therefore, any claim types or encounter data submitted on the CMS 1500 form correlate to the 837 Professional if data is submitted electronically.

The National Uniform Claim Committee has published a crosswalk between the CMS 1500 and 837 Professional, which can be viewed by using the following link:

http://www.nucc.org/images/stories/PDF/1500_form_map_to_837p_5010_v2-0_112011.pdf.

Detailed instructions for completion of the CMS 1500 can be viewed by using the following link:

https://www.azahcccs.gov/PlansProviders/Downloads/FFSProviderManual/FFS_Chap05.pdf

Submitting the CMS 1500 and the 837 Professional

Providers may submit CMS 1500 forms via a monthly paper batch submission to:

Division of Developmental Disabilities
Attn: Claims Department
Mail Drop 2HC1
P.O. Box 6123
1789 W. Jefferson Street
Phoenix, AZ 85007

Providers interested in using electronic billing clearinghouses to submit 837 Professional forms must first register with DES/DDD and complete testing prior to submitting electronically. Management Information Systems (MIS), Product Support can be contacted at DDDProdSupport@azdes.gov or calling 602-771-8138.

Additional information about HIPAA, CMS 1500 and 837 Professional can be found with the use of the following links

https://www.azdes.gov/main.aspx?menu=78&id=1080

https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/837P-CMS-1500.pdf

Manual (Paper) Claim Form Submission Requirements

Fee For Service (FFS)/ACUTE claims should be submitted on the appropriate CMS 1500 or UB-04 claim form and submitted to the Division. This should include submitting appropriate documentation for medical reviews if needed. If you are submitting requested medical documentation that was not previously submitted, please refer to the Claim Record Number.

In reference to Long Term Care (LTC), non-electronic submittal of a claim must be in the Division's approved Short Form format. The instructions and claim formats can be located on the Division's webpage. The following documents are required for manual (Paper) claim form processing.

Uniform Billing Template Short Form:
https://des.az.gov/content/providers-billing-documents

Submissions must include a Monthly Invoice Cover Sheet. The cover sheet is located at:
https://des.az.gov/sites/default/files/DDD-1590AFORFF.doc

For paper claim submission, the Uniform Billing Template short form must be:

- Dated
- Signed with an original signature and credentials
- Legible and either written in blue or black ink or typewritten

Information on the form can be corrected by drawing a line through the incorrect information, noting the information was an error and initialing and dating the notation. Correction fluid or tape is not allowed. The provider is responsible for delivery of manual claims to the Division, including the provision of adequate postage.

Mailing Address for Paper Claims, Resubmittals, and Medical Review Documentation:

Divisions of Developmental Disabilities
Attention: Claims Department
Mail Drop 2HC1
P.O. Box 6123
Phoenix, AZ 85007

What are Clean Claims?

Claims must meet the Division of Developmental Disabilities requirements for claims submission. AHCCCS defines a clean claim as a claim that may be processed by the Division without obtaining additional information from the provider of service or from a third party. Claims that require review for medical necessity or claims that are under investigation for fraud and abuse, are not considered clean claims.

A claim is considered clean on the date the following conditions are met:

- All required information has been received by DES/DDD.

- The claim meets all DES/DDD submission requirements.
- The claim is legible (permits electronic image scanning or manual input).
- Any previous errors in the data provided have been corrected.
- All medical documentation required for medical review has been provided.

How to Complete the DES/DDD Uniform Billing Template (UBT) – Electronic Billing for LTC

The UBT is divided into three tabs: Header, Details and Footer. The following table provides detailed information regarding the different fields within each tab, description of the fields along with examples and requirements for each.

Columns	Billing Document Field	Description	Requirements/Comments	Examples
	I) Header			
A	**ProvId**	Provider identification number; usually this is a Social Security number or Tax ID number.	9 digit number	123456789
B	**BillMonth**	Bill Month The month the services were performed.	3 character abbreviation for the month; if billing for several months the bill month should be the most recent month	JAN
C	**BillYear**	Fiscal Year Represents the Fiscal Year that services were provided. (Fiscal year runs from July 1st through June 30th)	2 digit number	16 (2016)
D	**ClaimType**	Claim Type Type of service being billed (Claim type will always be P2)	2 character alpha numeric	P2
E	**ProvNPI**	Provider NPI Group billers would use the group/company NPI.	10 digit number	1234567890
F	**ProvAhcccsId**	Provider AHCCCS ID All vendors are required to use the group/company AHCCCS ID.	6 digit number	123456
	II) Details			
A	**ProvSvcLocation**	Provider of service location The location where the services were provided.	2 alpha code	AA

Columns	Billing Document Field	Description	Requirements/Comments	Examples
B	**ContractNum**	Contract Number The contract number that was assigned when the contract was established.	5 digit number	12345
C	**ClientId**	Client Id (Assist Id) The ten digit assist identification number Number assigned to each member; can be verified in FOCUS.	10 digit number	1234567890
D	**SvcStartDate**	Service Start Date Service Start Date is the date that the service was delivered.	MM/DD/YY	01/01/01
E	**SvcEndDate**	Service End Date Date when service ended Service End Date should be the same as the Service Start date. (all services must be billed day by day)	MM/DD/YY	01/01/01
F	**SvcCode**	Service Code Represents the service being provided.	3 alpha code established by DES/DDD	AAA
G	**NursingHcpcsCode**	Nursing/HCPCS Code For nursing and durable medical equipment codes (only required for nursing services.)	5 alpha, numeric code	S9129
H	**DelUnits**	Delivered Units Number of units of service provided during the timeframe specified between service start date and service end date.	Number format (once you input a number it will automatically be converted to a number with two decimal places)	1.00

I	**AbsUnits**	Absent Units Therapy Services provided in natural setting can be billed for a half a session if the session was missed without proper cancellation in advance. Absences/No Shows do not constitute a billable unit in the Clinical setting.	Number format can only be "0.5". Once the 0.5 is input it will automatically convert to 0.50 If 0.50 is entered then 0.00 must be put in the DelUnits Column. 0.50 can only be used if DelUnits is zero; otherwise, this should be left blank.	*0.5* *or* (blank)
J	**Rate**	Rate Contracted Rate at which the services are provided.	Number format; must type in the rate with the decimal point and two places following the decimal	10.99
K	**TplCode1** **(TplCode2 = N, TplCode3 = Q, TplCode4 = AB, TplCode5 = AE, TplCode6 = AH, TplCode7 = AK, TplCode8 = AN, TplCode9 = AQ. These columns refer to additional third party payer coverage. Each must be completed separately when more than one third party payer is identified.)**	Third Party Liability Code 1 Master Carrier Identification (MCID) number for a third party payer insurance company; can be verified on the final authorization screen in FOCUS; if a waiver is granted, you do not have to list the MCID number.	5 digit number	12345
L	**TplAmt1** **(TplAmt2 = O TplAmt3 = R, TplAmt4 = AC, TplAmt5 = AF, TplAmt6 = AI, TplAmt7 = AL, TplAmt8 = AO, TplAmt9 = AR. These columns refer to additional third party payer coverage. Each must be completed separately when more than one third party payer is identified.)**	Third Party Liability Amount 1 Amount that was paid by a third party liability (TPL) carrier. Up to the contracted rate.	Number format; must type in the rate with the decimal point and two places following the decimal.	21.25

M	**TplReCode1** **(TplReCode2 = P, TplReCode3 = S, TplReCode4 = AD, TplReCode5 = AG, TplReCode6 = AJ, TplReCode7 = AM, TplReCode8 = AP, TplReCode9 = AS. These columns refer to additional third party payer coverage. Each must be completed separately when more than one third party payer is identified.)**	Third Party Liability Reason code 1 Third Party Liability payments that were applied to a member's annual deductible. Reason code can also be reported when there is copay/coinsurance as long as there is no other payment.	2 digit number Can only be the 2 character numeric code "01" and can be used if the payment was applied to a deductible, copay, or coinsurance as long as there is no other payment. If payment was not applied, leave blank.	01 or (blank)
T	**TotalAmtDue**	Total Amount Due The total amount billed for each claim line.	While Formatted as a number, this line contains a formula that will automatically calculate the total amount billed for each claim line. It will use the delivered units (or absent units), the contracted rate and any TPL payments. **Note:** This line will indicate "FALSE" until information is entered into the appropriate columns.	0.00 (FALSE)
U	**ProvControlNum**	Provider Control Number Providers control this field; it allows them to make notations (e.g., member name).	10 characters or digits	John Doe
V	**ProvOfSvcAhcccsId**	Provider of Service AHCCCS Id AHCCCS ID number of the individual therapist that performed the service.	6 digit number	123456
W	**ProvOfSvcNPI**	Provider of Service NPI NPI number of the individual therapist that performed the service.	10 digit number	1234567890

X	**PlaceOfSvc**	Place of Service Location code where the service was performed.	2 digit number	11 (office) 12 (home)
Y	**ProcMod1** **(ProcMod2 = Z, ProcMod3 = AA. These columns refer to additional Procedure Modifiers. Each must be completed separately when more than one Modifier is used.)**	Procedure Modifier 1 Modifier (when additional and tiered rate services are provided).	2 digit alpha code (otherwise, this should be left blank).	UF or (blank)
	III) Footer			
A	**TotalRecords**	Total Records Total number of claim lines completed in the details section.	Number format. **Note:** When using the Excel spreadsheet format of the Uniform Billing Template, the claim information begins on line two; therefore, one line must be subtracted from the number that the last claim is entered on.	115

B	**TotalUnits**	Total Units Total number of units billed in details section.	Number format; must type in the rate with the decimal point and two places following the decimal. Alternatively, if using the Excel spreadsheet format of the Uniform Billing Template, the sum can be automatically calculated from the **DelUnits** and **AbsUnits** columns of the details tab. Starting at line two, left click and drag down the **DelUnits** and/or **AbsUnits** columns until reaching the last claim line. At the bottom of the spreadsheet on the right side, the sum of the units billed will show. Click back to the footer tab and input the total number of units into this column.	536.00
C	**TotalAmount**	Total Amount Total amount of the claims billed in the details section.	Number format; must type in the amount (rate) with the decimal point and two places following the decimal. Alternatively, if using the Excel spreadsheet format of the Uniform Billing Template, the sum can be automatically calculated from the **TotalAmtDue** column of the details tab. Starting at line two, left click and drag down the **TotalAmtDue** column until reaching the last claim line. At the bottom of the spreadsheet on the right side, the sum of the amount billed will show. Click back to the footer tab and input the total amount into this column.	2326.12

For further information regarding formatting requirements of the Uniform Billing Template, please review information posted on our website under, “Uniform Billing Template (UBT) Billing Format Provider’s Instruction Guide”.

What is SFTP?

In reference to electronic billing, after the proper completion of the billing documents (Uniform Billing Template and Cover Sheet), they should be uploaded in the SFTP (Secure File Transfer Protocol) site. The SFTP site is an area where Providers upload billing files for processing. There are two folders in the SFTP site, CLAIMSIN and CLAIMSOUT.

CLAIMSIN: This is the folder where the files are uploaded to initiate the electronic billing process (coversheet and uniform billing document). All files uploaded in this folder are transferred into the "CLAIMSOUT" folder by 3:00 p.m. (Monday through Friday, excluding holidays).

CLAIMSOUT: All billing files (coversheet and uniform billing document) are transferred by 3:00 p.m. (Monday – Friday excluding holidays) into the "CLAIMSOUT" folder from the "CLAIMSIN" folder. To ensure that the billing files have been uploaded properly, it is recommended that providers log into the SFTP site the following day and access the "CLAIMSOUT" folder to view any notifications in relation to the last file submitted.

File Naming Convention for the SFTP Site

The naming convention for the monthly Coversheet and the UBT is the same. The file name should include the four-character code assigned to the agency, followed by the fiscal year, the month of billing and a three digit number, for example: "001" (a total of 11 characters).

Fiscal Year reflects the time from the beginning of July to the end of June of a given year and is not the same as a calendar year. For example F.Y. 2016 is the time period from 1st of July 2015 through 30th of June 2016.

For example, consider the file name, "**ABCD1606001**". The file name can be divided into the following components:

- "ABCD" – Provider assigned four character code
- "16" - Fiscal year
- "06" - Month of billing (June)
- "001"- 1st file submitted in the month

Submitting the Uniform Billing Template and Coversheet

The Uniform Billing Template and Coversheet can be submitted to DES/DDD once each month by using the following secured link.

1. Go to the SFTP site: https://ftp.azdes.gov
2. Enter in the appropriate User Name and Password (provided by DDD/MIS)
3. Click **OK**

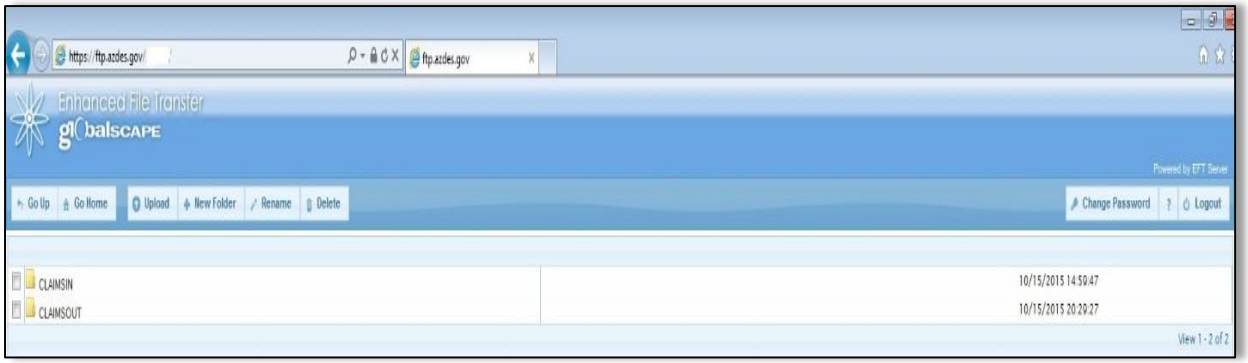
Image 1

Steps for Uploading the Billing Files

After logging into the FTP site two folders will be displayed, a CLAIMSIN folder and a CLAIMSOUT folder.

1. Click on **CLAIMSIN**

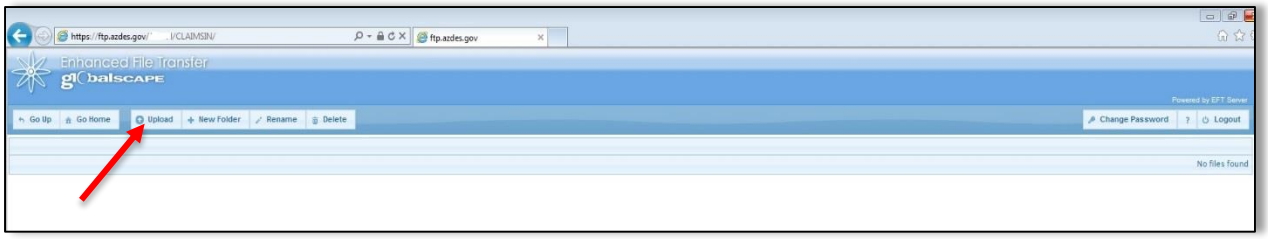
Image 2



After clicking **CLAIMSIN** there will be a blank screen like the one shown in Image 3.

2. Click **Upload**

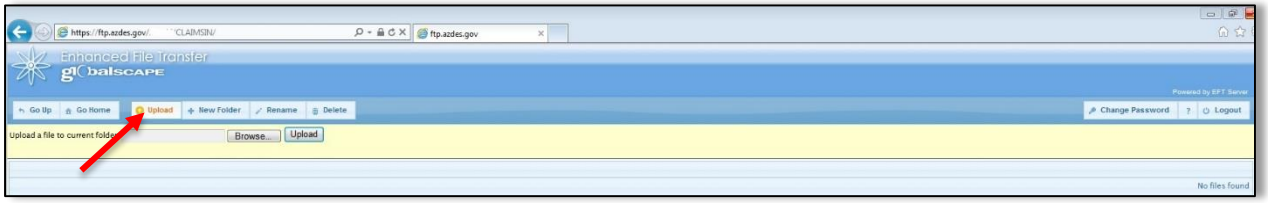
Image 3



3. Select the appropriate billing files for submission

4. Click **Upload** again

Image 4



The Monthly Coversheet and Uniform Billing Template are processed at 3:00 p.m. (Monday through Friday excluding holidays).

Confirmation of Billing Files Submission

To verify that the billing files have been uploaded properly, the following day log into the SFTP site, click the **CLAIMSOUT** folder and view any notifications in regards to the file that was submitted. There are two types of notifications.

a) **File Processed Successfully:** The file processed successfully along with the date of processing. In this case, there will also be an excel icon available which reflects the "Billing Detail Report."

b) **File Not Processed Successfully**: The file did not process due to errors. There will be a description of the error message along with the claim lines that may be causing the error (see below for details).

View Notification

The files in the "CLAIMSOUT" folder notifies Providers whether or not the billing file (UBT) and coversheet have been processed successfully and if not, information about potential errors.

1. Click on **CLAIMSOUT**

Image 5

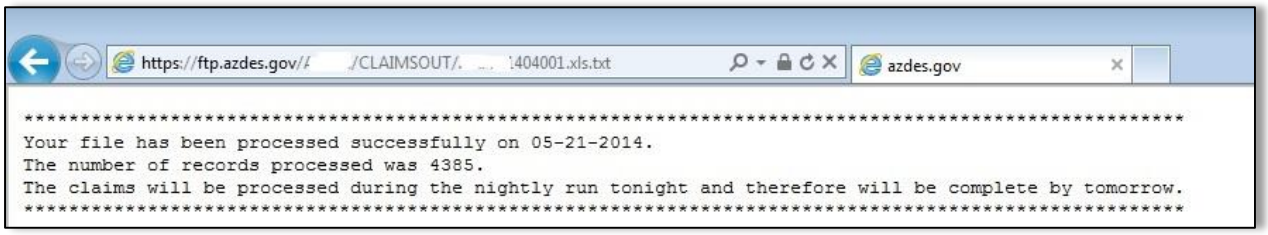
2. Click on the **Text** icon

Image 6

The text file will display whether or not a file has processed successfully, below are examples of both a successful and unsuccessful upload.

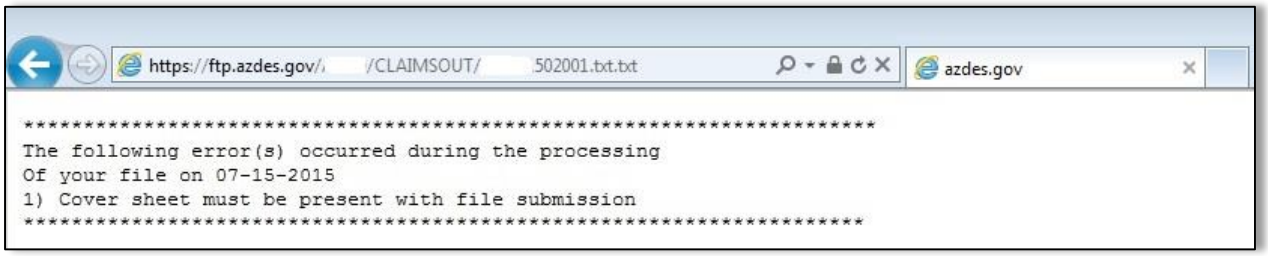
Example of a Successful upload:

Image 7



Example of an Unsuccessful upload:

Image 8



View Billing Detail Report:

1. Click on **CLAIMSOUT**
2. Click on the **Excel** icon

Image 9

What to Do If the Billing Files Were Not Processed Successfully?

There could be multiple reasons for an unsuccessful submission of the billing files. The exact error message would depend on the nature of the issue. If the billing file is not submitted successfully, the only notification available in “CLAIMSOUT” folder would be a .txt (Text) file. There will be no notification for the .xl (Excel) File.

It is recommended that providers review the error message available via the .txt file. Based on the details of the error, providers should make necessary corrections and resubmit the files (cover sheet and Uniform Billing Template).

If difficulties are encountered with either of the above processes, providers are encouraged to contact the Provider Relations Unit via: DDDProviderRelations@azdes.gov

Billing Rates - RateBook

The DDD RateBook is an important document which provides information and rates for all services offered by DDD. Providers must review and understand rates and limitations for each approved service before billing. The RateBook can be accessed at the following link:

https://des.az.gov/sites/default/files/media/DDDRateBook.pdf

In addition, the "Look up File" available via the following link helps providers find specific rates based on particular service codes.

https://des.az.gov/sites/default/files/media/Division%20Rate%20Look%20Up%20File_v20160202.xls

What is Third Party Liability (TPL)?

Third Party Liability (TPL) can be defined as resources available from a person or entity that by agreement, circumstance, or otherwise is liable to pay all or part of the medical expenses incurred by an AHCCCS/DDD member. TPL refers to the responsibility of parties other than Division of Developmental Disabilities (DDD) to pay for health insurance costs incurred by an Arizona Health Care Cost Containment System (AHCCCS) member.

DDD/AHCCCS is the payer of last resort, which means DDD/AHCCCS will not pay a claim for which someone else may be responsible until the party liable before DDD has been billed. For the most part, this means providers are responsible for billing third parties before billing DDD/AHCCCS.

Reversal (Adjustments) Process

After a claim has been paid by DDD, errors (data corrections or revised payments) may be discovered in the paid amounts that were billed by the provider. For Fee For Service/ACUTE claims, if the claim was submitted via a Manual Claim form (CMS 1500 or UB-04), providers are required to resubmit a corrected claim form while referring to the original CRN the claim was issued payment on. A difference of payment may be issued based on the review of the received documentation.

For LTC claims, errors may require submission of required documentation in order to adjust specific claim lines in FOCUS for rebilling and payment purposes. This process is called Reversal (Adjustment). In order for DDD to process a Reversal/Replace request, the provider should contact the Provider Relations Unit at 1-866-229-5553. After receiving the request, specific documentation will be emailed to the provider, which should be completed by the provider and submitted back to DDD.

The processing of this request may take 3 to 4 weeks. Providers will receive an email notification once the Reversal has been completed and when the corrected billing has processed. Providers can refer to the original Bill ID, Billing Detail Report for verification of the Reversal process and can also review the Check Detailed Report for further verification.

Any questions regarding the Reversal process can be targeted to Provider Relations Unit at: DDDProviderRelations@azdes.gov

Reconciling Paid Claims

Payment information, including payment status, is provided by DES/DDD. Providers are responsible for reviewing and reconciling payment information and accompanying payments with their accounts receivable.

How to Reconcile Payments

In regards to electronic billing, after the upload and acceptance of the Uniform Billing Template (UBT) and Cover Sheet, FOCUS generates the "Billing Detail Report". The report indicates which claim lines were paid and which claim lines may be in the pended status. The Billing Detail Report has a paid section with specific transaction numbers for each paid claim line.

When a payment is made, the "Check Detail Report" is generated, reflecting the exact amount paid to the provider based on the paid claim lines of the Billing Detail Report.

To obtain Payment Information:

1. Log into the https://des.az.gov/services/disabilities/developmental-child-and-adult/help-providers#
2. Log into FOCUS (right hand side)
3. Click on **Professional Billing System**
4. Click **Reports**
5. Click **Billing Detail Report**

Overpayment

Through the reconciliation process, if a provider discovers any overpayment for services rendered, the provider must notify the Division followed by submitting a Reversal (adjustment) request. The provider should contact the Provider Relations Unit at 1-866-229-5553. After receiving the request, specific documentation will be emailed to the provider, which should be completed by the provider and submitted back to DDD.

Time Frames - Initial Billing Submission and Resubmissions

According to standard terms and conditions, the Division is not obligated to pay for services provided without prior authorization. Claims for services delivered must be initially received by the Division no later than nine (9) months (6 months in case of FFS/Acute Care Services) after the last date of service as indicated on the claim. Claims should be submitted within the specified time period from the date of service for a first submission to retain appeal rights, whether the other insurance explanation of benefits has been received or not.

A resubmitted claim shall not be considered for payment unless it is received by the Division as a clean claim no later than twelve (12) months after the last date of service shown originally on the claim.

The Division's claims processing system deny claims with errors that are identified during the editing process.

- A provider can review these errors using the "Billing Detail Report" which can be accessed via the following path.

- Log into the https://des.az.gov/services/disabilities/developmental-child-and-adult/help-providers#
- Log into FOCUS (right hand side)
- Click on **Professional Billing System**
- Click **Reports**
- Click **Billing Detail Report**

- Providers must correct claim error and resubmit claims to the Division for processing within the 12-month time period (from the date of service).
- Acute Care providers should reconcile denied claims based on Provider Remittance Advice.

Provider Questions, Concerns and Support

Any questions regarding this document, billing process or billing inquiries should be addressed to the Provider Relations Unit at: 1-866-229-5553 or DDDProviderRelations@azdes.gov.